

*Michigan Association
of
Health Plans*

Dominick Pallone, Deputy Director

4/29/2016



MAHP: Who We Are

- The Michigan Association of Health Plans is a nonprofit corporation established to promote the interests of member health plans.
- MAHP's mission is "to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan."
- Represents 14 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Our member health plans employ about 8,000 persons throughout the state.
- Member health plans provide coverage for more than 3 million Michigan citizens – nearly one in every three Michiganders.
- Member health plans collect and use health care data, support the use of "evidence based medicine", and facilitate disease management and care coordination in order to provide cost-effective care.



Our Members

Aetna Better Health of Michigan 1,2,3

Fidelis SecureCare of Michigan, Inc. 3

Harbor Health Plan 1, 2

Health Alliance Plan (HAP/Midwest) 1,2, 3

McLaren Health Plan 1, 2, 3

Molina Healthcare of Michigan 1 ,2 ,3

Physicians Health Plan 1

Total Health Care Plan Inc. 1, 2

Grand Valley Health Plan 1

Meridian Health Plan 1, 2, 3

Paramount Care of Michigan 1

Priority Health 1, 2, 3

UnitedHealthcare Community Plan 1, 2, 3

Upper Peninsula Health Plan 2, 3

1 = Commercial Health Plan

2 = Medicaid Health Plan

**3 = Medicare Advantage or
Medicare Special Needs Plan**



MAHP VISION

- *By 2020, Michigan will provide health insurance coverage and options to more than 99% of the State's population.*
- *By fostering competition, by 2020 Michigan will become one of the top 25 competitive states for health insurance. Today, we are third least competitive.*
- *Michigan's Health Plans will work with partners in government, the provider community, community organizations, and business to improve the health status of Michigan residents.*

Health Insurance in Michigan

Working Through the Maze of Insurance Coverage

- HMO – Health Maintenance Organization
- PPO – Preferred Provider Organization
- EPO – Exclusive Provider Organization
- POS – Point Of Service
- ASO – Administrative Services Only
- ACO – Accountable Care Organization
- ICO – Integrated Care Organization
- MCO – Managed Care Organization
- Individual Market – Exchange
- Small Group
- Large Group
- ERISA Exempt – Self-insured
- Medicaid
- Medicare

Regulation of Health Insurance

Predominantly regulated by the Michigan Department of Insurance and Financial Services (DIFS) with authority derived from the Michigan Insurance Code (MCL 500.100 – 500.8302)

- Benefit Flexibility
- Commercial Rate Filing
- Rules and Standards for Rates
- Financial Solvency Standards
- Rule Promulgation by Director/Commissioner
- Network Adequacy
- Network Participation and Provider Contracts
- Required Benefit Plan Offerings (Mandates)
- Commercial Contract and Policy Form Filings
- Self-Funded/ASO Arrangements
- Geographic Limits on Product/Service Areas
- Guaranteed Issue
- Guaranteed Renewal
- Appeal of Benefit Denials

Underlying Cost Pressures

- Federal Insurance Premium tax (1.45% in 2014—2% in 2015 and 2016, 2.5% in 2017 and will continue to increase rate until 2020.
- 2.3% Federal excise tax on manufacturers of medical devices
- 3.5% surcharge on premiums for Insurance Exchange
- Limits on Medical Underwriting (Age/Smoking/Geography). 20% population drives 80% cost because of chronic diseases and co-morbidities
- Benefit design changes forced on carriers (EHB/QHP)
- Minimum Medical Loss Ratios – Large Group 85%, Small and Individual 80%
- Cost shifting concerns (Government payers, auto, uninsured)
- Pharmacy cost trends (Specialty Drugs leading the way)

What Health Plans Do

Utilization Management:

- Techniques that provide safeguards against inappropriate care
- Prior authorization
- Claims review to identify inappropriate care

Disease & Case Management:

- Early identification of high-risk patients for early intervention
- Focus attention on individuals based on indicators (use of analytics)

Network Design:

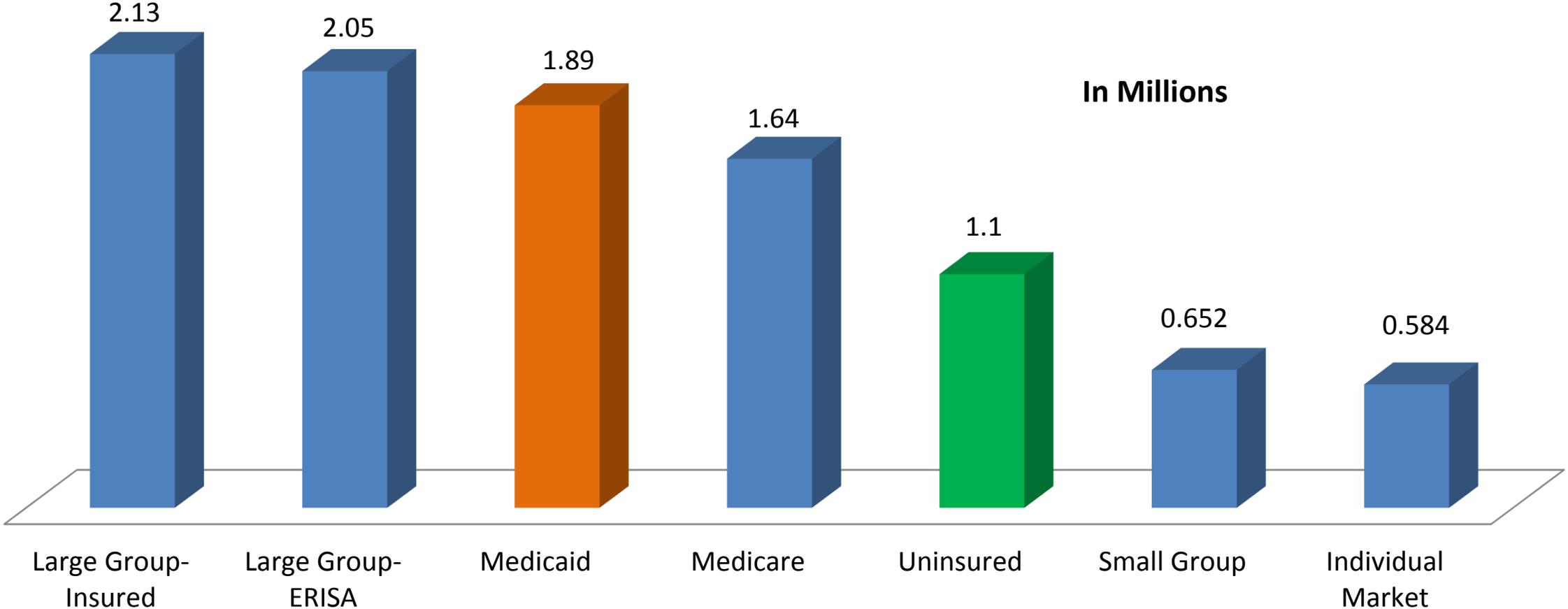
- Carefully pooling providers who provide excellent care at lower costs
- Tiered networks

Benefit Design:

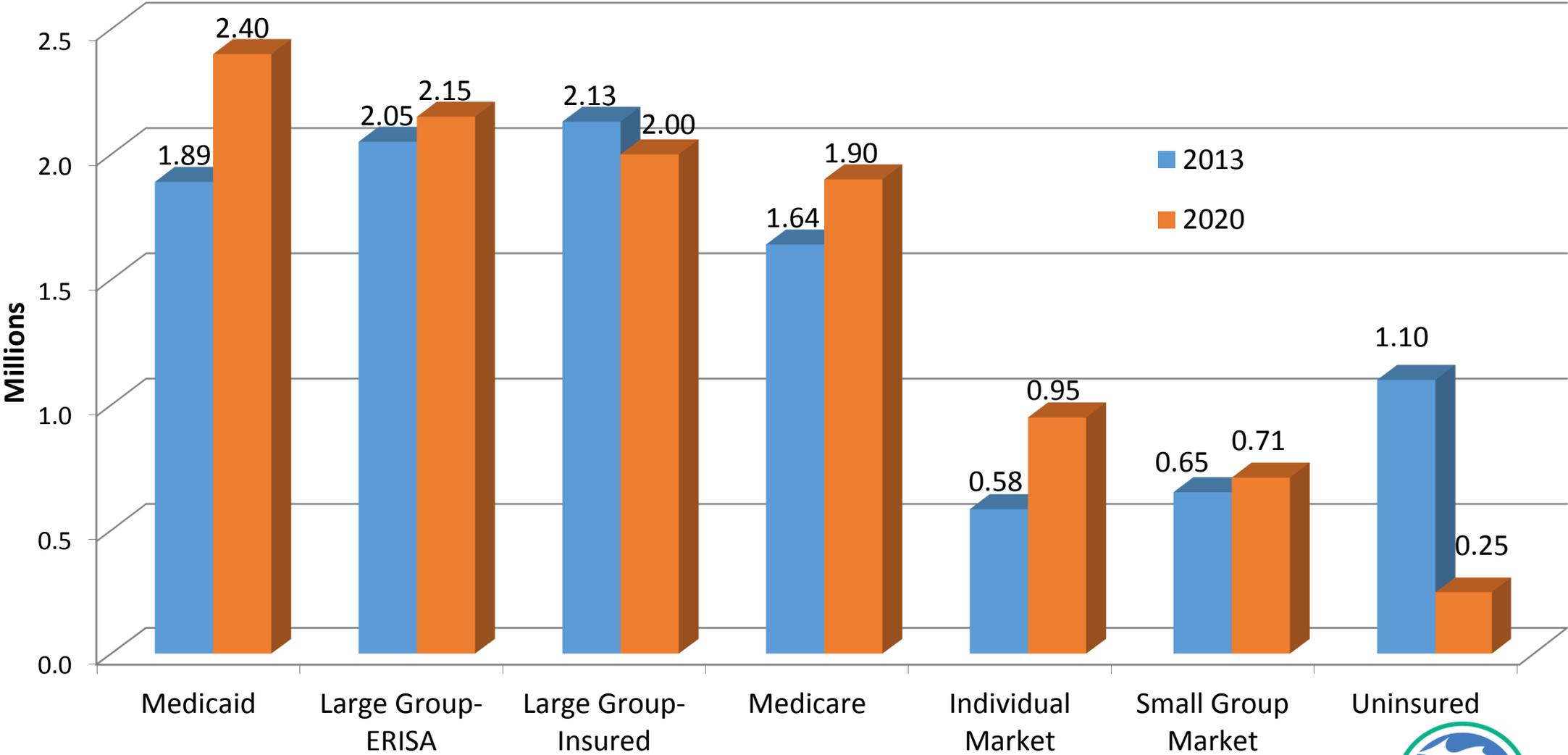
- Cost sharing through copays and deductibles
- Saving/spending accounts (HSAs, FSAs)

Where Michiganders got insurance

(before Healthy Michigan Plan)



Michigan health care coverage 2013 – and 2020



Affordable Care Act Overview

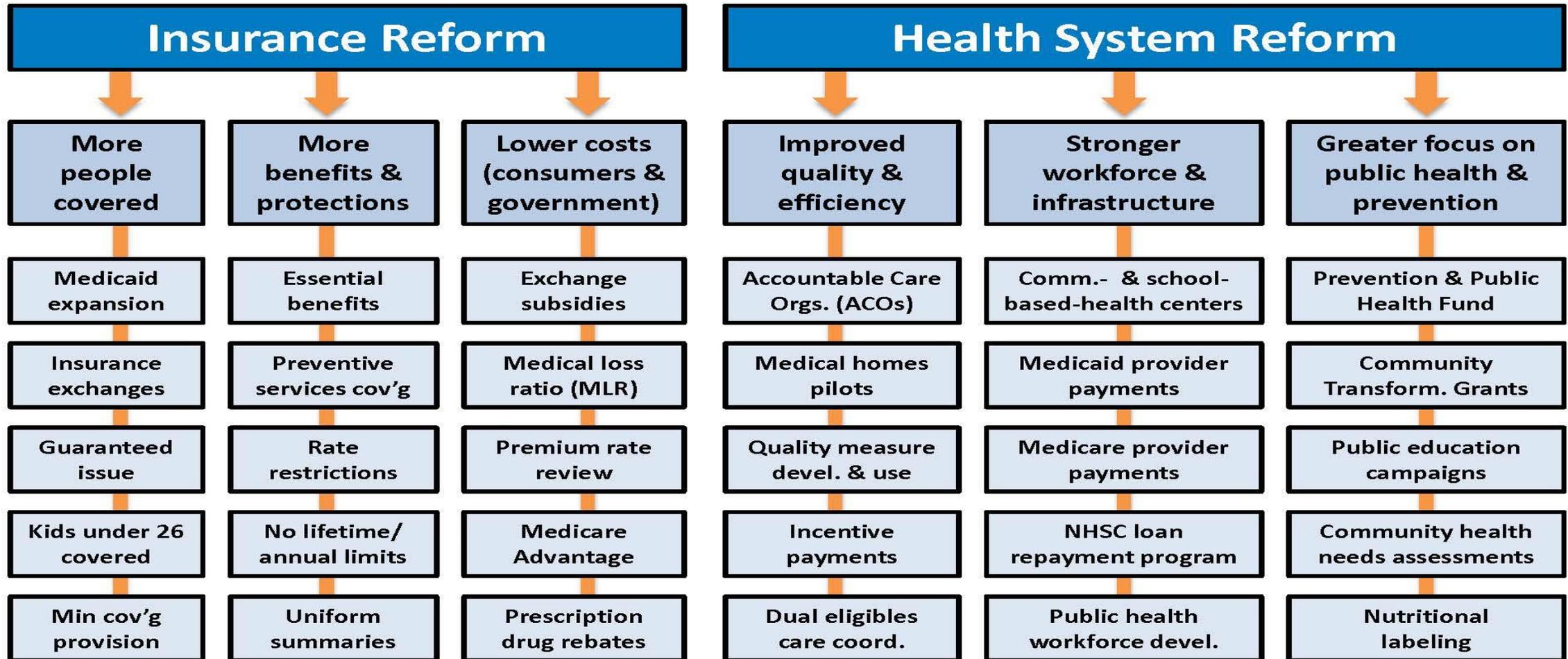
Selected Provisions

August 2012



American
Public Health
Association

This chart provides a broad overview of the structure of the Affordable Care Act (ACA), the health reform law enacted in 2010. It does not address all provisions in the law. See next page for brief explanations of these provisions. Visit www.healthcare.gov for a full list of provisions and more detailed explanations. Visit <http://www.apha.org/advocacy/Health+Reform/> for more ACA resources.



Adapted from Dr. Donald Berwick's presentation "The Triple Aim: Health, Care, and Cost: Public Health and the Health Care Transition," given June 2012 at APHA's mid-year meeting. Find this document at <http://www.apha.org/advocacy/Health+Reform/ACAbasics/>.

Qualified Health Plans

- Plans/Products divided into 5 categories based on actuarial value:
 1. Bronze – 60%
 2. Silver – 70%
 3. Gold – 80%
 4. Platinum – 90%
 5. Catastrophic plans
- All products must cover the “Essential Health Benefits” as selected by each State
- Consumer Protections:
 - Ban on annual and lifetime caps
 - Prohibit rescissions
 - Web-based portal
 - 1st Dollar coverage for prevention & wellness
 - Coverage of Emergency Services
 - Dependent Coverage (age 26)

Employer Responsibility

- Must provide health insurance to full-time employees of large groups
 - “Employer Mandate – Play-or-Pay (delayed until 2015/16)
 - 50+ FTEs – must provide insurance to at least 95%
 - Minimum value – no less than 60% actuarial value
 - Affordable – cost to employee for self-only coverage cannot exceed 9.5% of household income
 - Minimum value calculator enables employers to test
 - Penalty if at least one employee receives tax credit via individual market
 - \$2,000 per employee not covered (minus first 30 employees)
 - If not affordable, penalties would also apply
- Small Group Exchange – Small Business Health Options Program (SHOP)
 - Optional
 - 2-50 employees
 - Less than 25 employees making less than \$25,000 average wage may be eligible for tax credits

Michigan's Insurance Exchange

It's working

- Easier for consumers to shop: Promotes price competition in the individual and small group markets through greater transparency.
- Michigan one of 37 states using federal platform; our second year as a Partnership Exchange with federal government.
- Boosting competition! Insurers offering products up from 12 in 2014 to 16 in 2015; vastly increased selection of plans. According to an analysis by the Commonwealth Fund, the average premium for a silver plan sold on the Exchange decreased by 5%.

People are using it

- 299,750 individuals who selected a health plan using the Exchange (as of January 2015). One third were new users of the Exchange.
- Subsidy is important: 88% of individuals in Michigan who selected a health plan using the Exchange qualified for financial assistance (2015).
- SCOTUS decision on King v. Burwell secured APTCs.



Exchange Determines Eligibility

- In addition to enrolling individuals in plans on the exchange, the exchange determines eligibility for:
 - Medicaid – up to 138% FPL
 - SCHIP (MI Child)
 - Premium tax credits
 - Reduced cost-sharing
- Premium tax credit is based on the premium for the 2nd lowest cost silver plan and varies by income:
 - 138-150% FPL 3-4% of income
 - 150-200% FPL 4-6.3% of income
 - 200-250% FPL 6.3-8.05% of income
 - 250-300% FPL 8.05-9.5% of income
 - 300-400% FPL 9.5% of income

Medicaid

- Michigan Medicaid program has chosen to use HMOs to deliver almost all of the Medicaid benefits
- 1.8 million traditional Medicaid beneficiaries (1.4 million in Managed Care)
- Mostly “moms and kids” (950,000) and disabled population (350,000)
- Healthy Michigan Program (Medicaid Expansion) with an additional 600,000 beneficiaries
- Expanding enrollment into managed care for Dual Eligible (Medicare/Medicaid)
- Expanding enrollment into managed care for Children’s Special Health Care Services
- With HMP – one in four in Michigan is on Medicaid
- Over 50% of all births are paid for by Medicaid

Medicaid

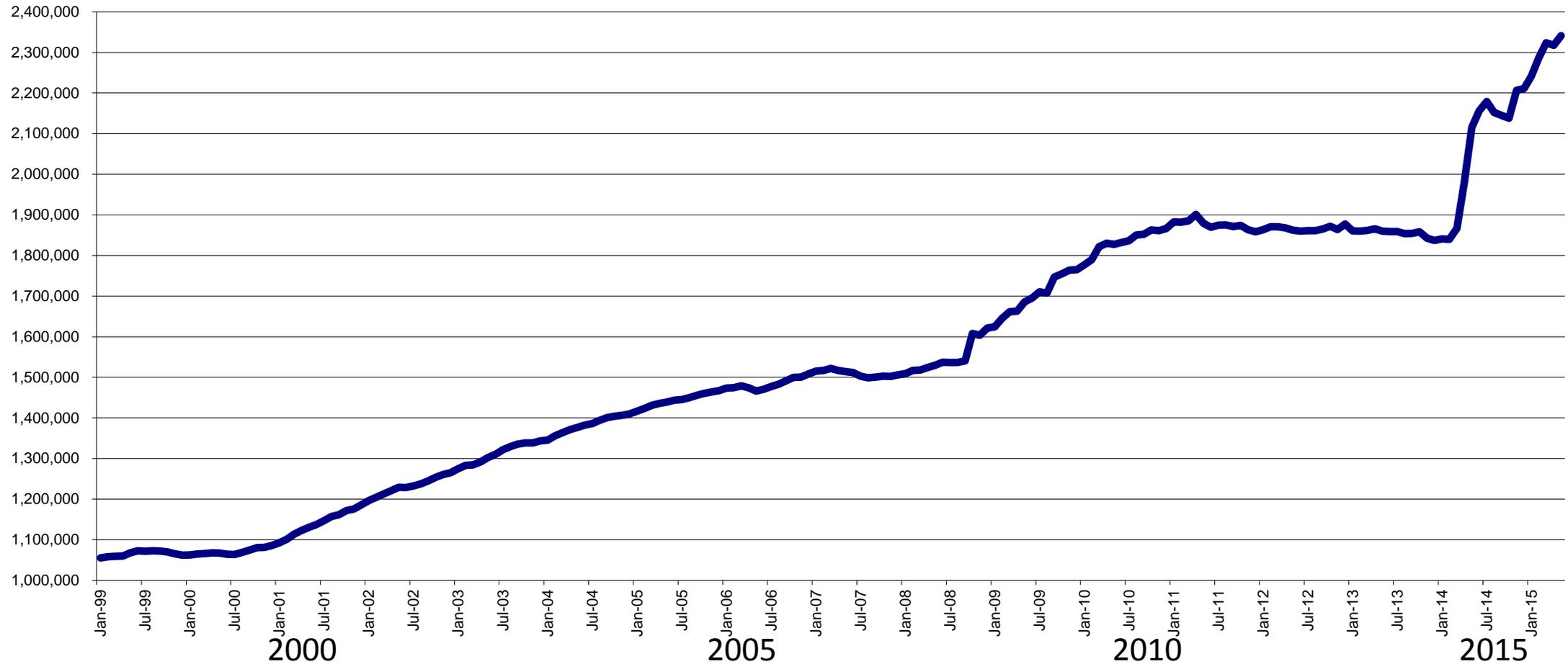
- Initiated in 1970's. State contracted with HMOs on a voluntary enrollment basis
- In the late 1980's, expanded to Clinic Plans – unlicensed risk-based for outpatient services, shared risk with the State for inpatient services
- In 1997, mandated managed care state-wide contracting with over 30 qualified health plans competing on price bids
- Re-contracted in 2000, 2004, 2009 and 2016 using competitive bid on quality, network, capacity, and financial status
- Estimated 3% of the State's GDP
- Currently 11 Medicaid Health Plans (was 14). Mix of profit and non-profit, local and national.

Medicaid

Medicaid Health Plan Responsibilities:

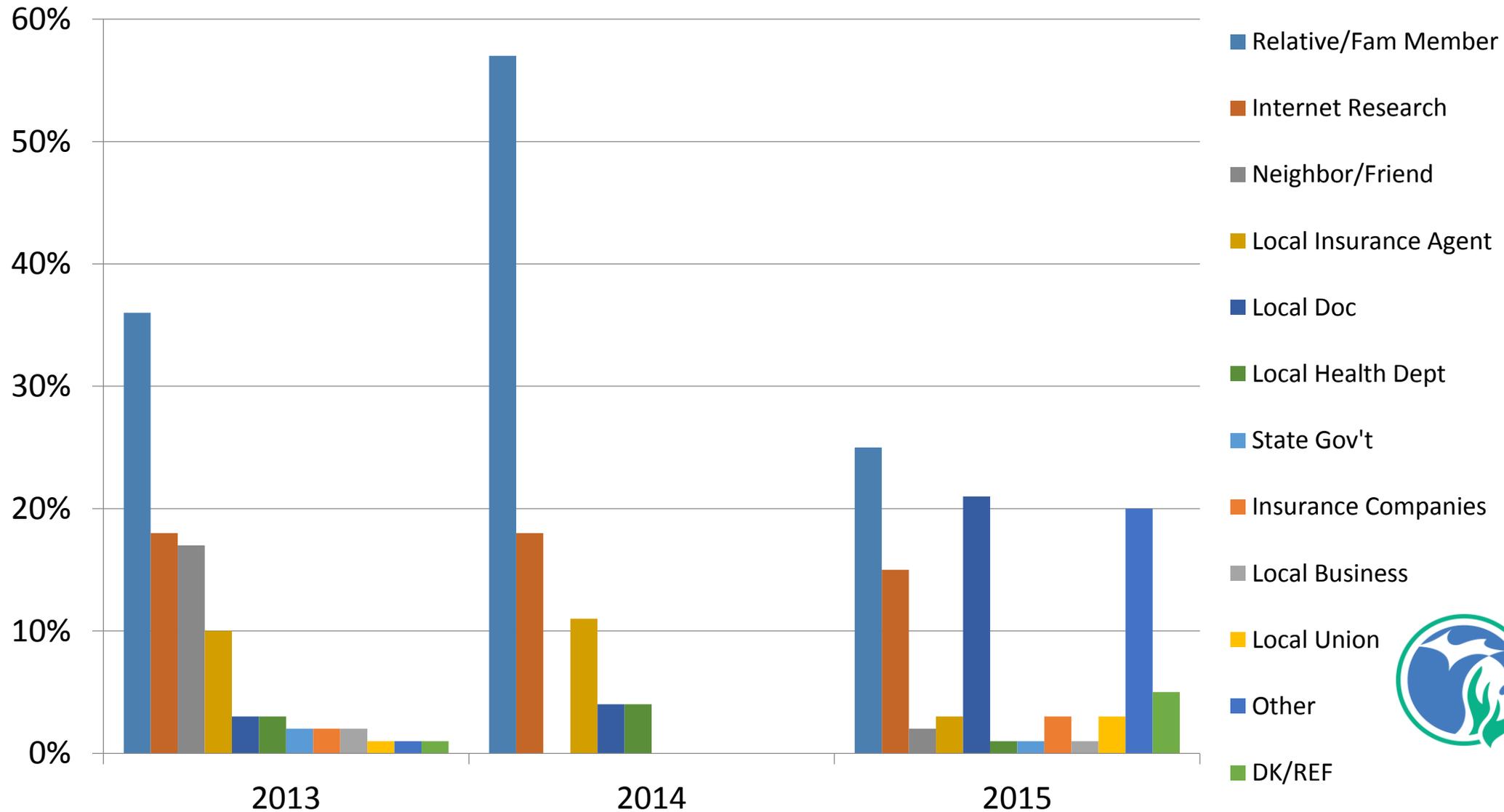
- Assignment to a primary care provider within 30 days of enrollment
- Distribution of member materials
 - Member handbook and ID cards
 - Provider network information
 - Member newsletters
 - Website
- Health risk assessments and enrollment into medical management programs
- Member and provider grievance and appeal processes
- Enrollee rights and responsibilities
- Contracting/Credentialing of Provider Network
- Care coordination with public, community provider, local behavioral health providers.
- Provider claims payment and processing
- Quality assessment and performance improvement
- Utilization management activities
- Program integrity – fraud, waste and abuse
- Annual compliance review and reporting

Total Michigan Medicaid Enrollment

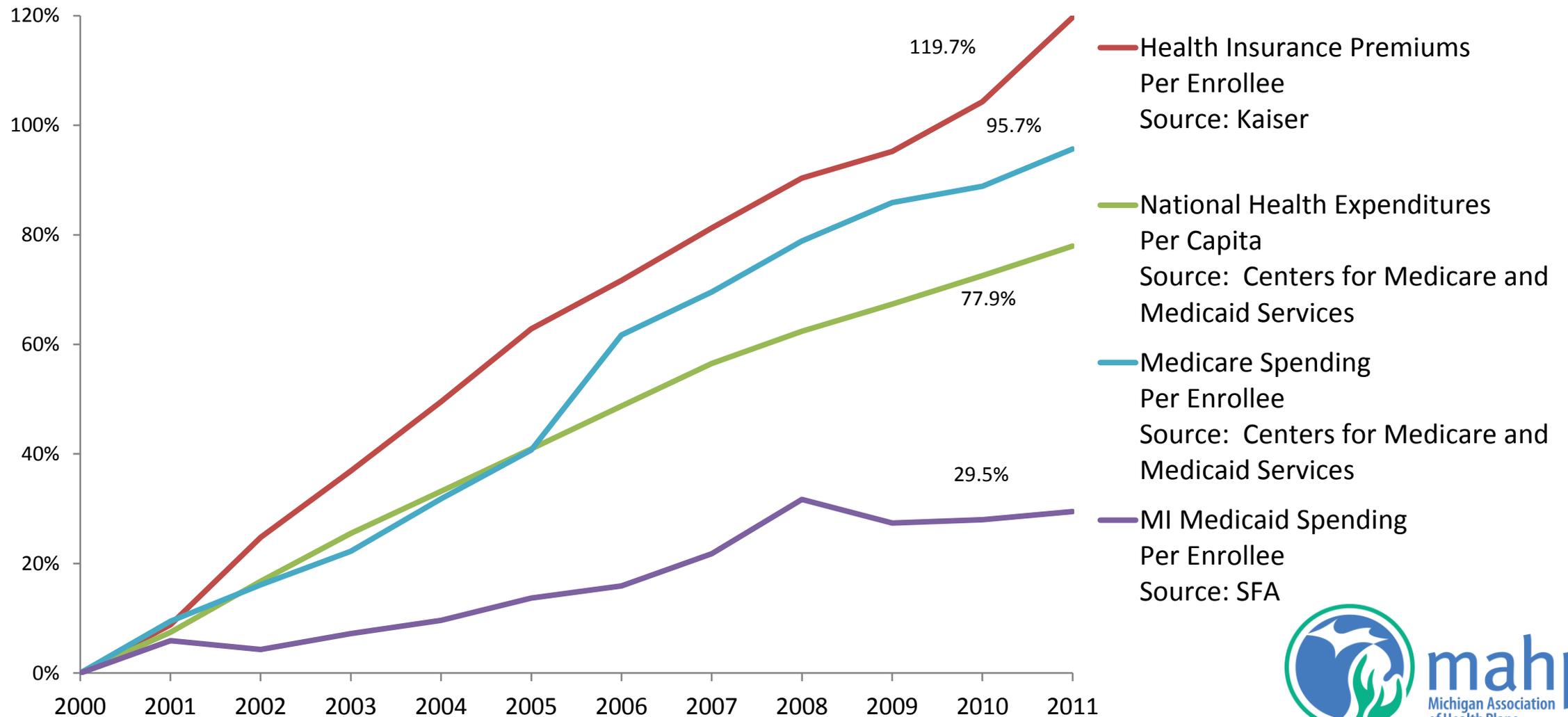


Source: HMA, based on data from Michigan Departments of Human Services and Community Health.

Most Trusted to Help Make Insurance Decisions



Historical Costs of Health Care 2000-2011



General Issues Facing our Industry

Keeping Health Insurance Affordable

- Major Cost Drivers (Pharma)
- Uncompensated care from uninsured (largely from ER)
- Legislative benefit mandates
- Consumer behavior and unhealthy lifestyle (diet, smoking, treatment adherence)
- HIPPA - 5010 transaction codes. Electronic Claims and Encounter (837) transactions
 - US HHS requires the health care industry to upgrade electronic standard transactions
 - Rules apply to Health Plans, Hospitals, Providers and other health care professionals
 - Effective January 2012
- Medical Loss Ratio Pressures – impact from federal reform
- ICD-10 Transition

General Issues Facing our Industry

- Change to ICD-10 – will radically change how provider input diagnostic and billing codes
- New codes reflect modernization of healthcare. Allows providers to capture greater detail about patients and help to better coordinate a patient's care across different providers and over time

ICD-9 = 13,000 codes

ICD-10 = 68,000

- “It takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!” – The Red Queen, Through the Looking Glass.

www.cms.gov/icd10

www.youtube.com/watch?v=AEW2cXqXTSQ&feature=player_embedded



ICD-10 Codes

- V97.33XD: Sucked into jet engine, subsequent encounter
- V00.01XD: Pedestrian on foot injured in collision with roller-skater, subsequent encounter
- Y93.D: Activities involved arts and handcrafts
- Z63.1: Problems in relationship with in-laws
- R46.1: Bizarre personal appearance
- Z99.89: Dependence on enabling machines and devices, not elsewhere classified (iPhone?)

We Can Do Better Using Technology

- 20% of patient records not transferred in time for appointment
- 25% of patient tests to be re-ordered
- 1 in 3 hospitalized patients “harmed” during stay
- 1 in 5 Medicare Patients re-admitted within 30 days
- 63% of patients don’t know their health care costs and 10% never find out
- 33% of health care expenditures don’t improve health

(Source: Institute of Medicine/Best Care)

Use of Advanced Analytics

- “That which is not measured cannot be managed or improved”
- Attempts to define and measure “cost” and “value”
- Uses various data sources and statistics to predict future events and behaviors
 - Predictors of hospital readmissions, length of stay, patient outcomes, etc...
- Use as a “value-added evaluation tool”
 - Evaluate provider groups or individuals based on patient outcomes weighted by population mix and payer mix
- Potential use as traditional Business Intelligence tool to streamline provider business activities

Focus on Preventive Health

- Prevention involves a wide range of strategies from patient and provider education, to ensuring that appropriate health screenings take place, to community-wide efforts to help citizens choose healthier lifestyle behaviors
- Preventive health care services are one of our most effective tools for improving health outcomes and containing rising health care costs
- Health Plans have created and implemented a variety of initiatives to improve quality and access in internal administration, clinical disease management, delivery of services, and community outreach
- Partnerships between Health Plan, employer, and employee – internet based programs to use health risk appraisal tools blended with wellness programs with rewards for employees accepting more accountability.
- Growth of “Wellness Plans.” Products that provide premium rebates based on members completing specific preventive programs.

The Future

Competition in the Industry: Wrong Focus?

- Current competition is focused on price. Creates a zero-sum game with cost shifting rather than cost reduction. (Most Favored Nation Clauses)
- Destruction of value because providers are often forced to focus on highly reimbursed services
- Competition should occur at the level of prevention and treatment – quality measures
- Goal should be to improve quality of outcomes per dollar expended

Payment Incentive Reform:

- Majority of current payments based on procedures performed – basis of FFS
- More care and expensive care does not always equal better care
- Payments starting to focus on outcomes achieved
- Population Health Management

Benchmarks for Future Trending

Attributed Members



Percent of commercial plan members attributed to a provider participating in a payment reform contract, such as those members who choose to enroll in, or do not opt out of, an Accountable Care Organization, Patient Centered Medical Home or other delivery models in which patients are attributed to a provider.

15% NATIONAL AVERAGE

Share of Total Dollars Paid to Primary Care Physicians and Specialists

Of the total outpatient payments made to primary care physicians and specialists, 71% is paid to specialists and 29% is paid to PCPs. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.



Non-FFS Payments and Quality

Quality is a factor in **97%** of non-FFS payments



Quality is *not* a factor in **3%** of non-FFS payments

Transparency Metrics

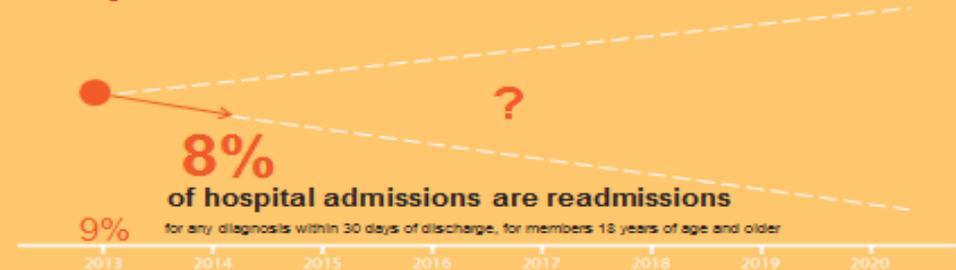
97% of plans offer or support a cost calculator

63% of hospital choice tools have integrated cost calculators

74% of physician choice tools have integrated cost calculators

82% of plans reported that cost information provided to members considers the members' benefit design relative to copays, cost sharing, and coverage exceptions

Hospital Readmissions*



* Derived from data submitted to eValue360 using NCOA's episode readmission measure. Not an official NCOA benchmark.

Provider Payment Models

BASE PAYMENT

Fee For Service

Bundled Payment

Global Payment



Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

PERFORMANCE-BASED PAYMENT OR PAYMENT DESIGNED TO CUT WASTE
(financial upside & downside depends on quality, efficiency, cost, etc.)



UNDER MY PLAN,
ALL PRE-EXISTING
CONDITIONS WILL
BE COVERED!!!

-EXCEPT ONE.



BUZZ-NORMAN
The Miami Herald

Then and now...

The growing cost of prescription drugs



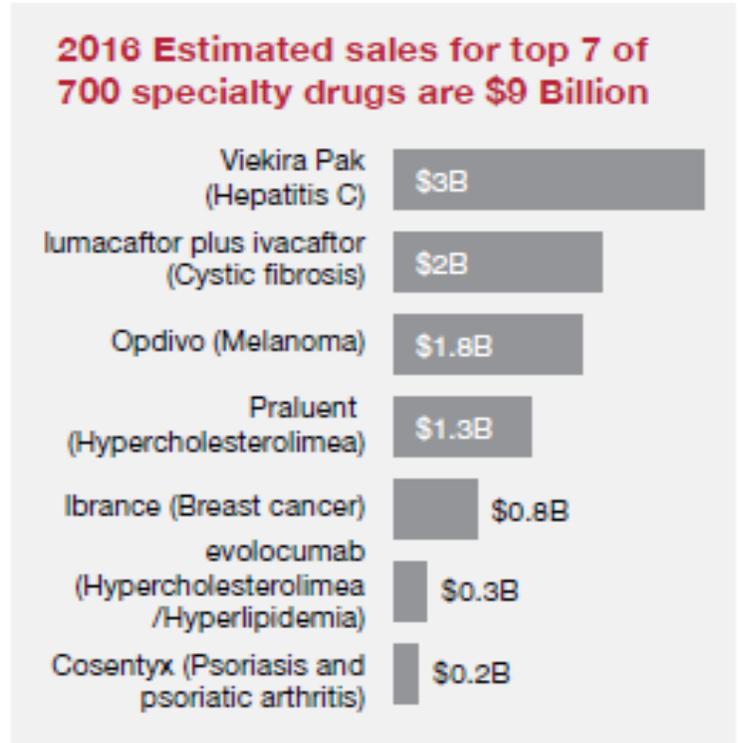
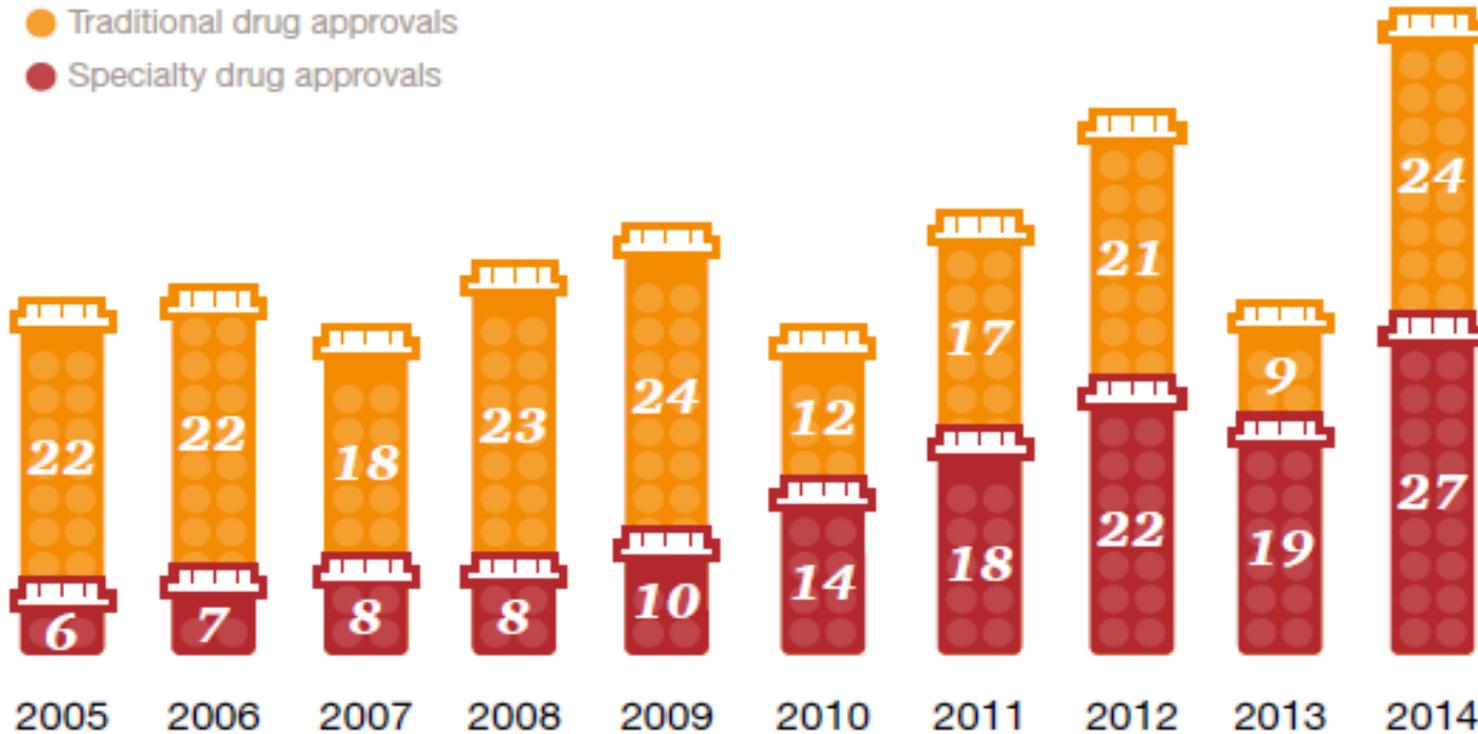
As drug prices increase,
so does the cost of health insurance

Source: AHIP



Figure 11: Specialty drug approvals continue to race ahead

Specialty drug approvals have surpassed traditional drugs in the past five years, and based on the FDA pipeline this trend will continue



Source: PwC Health Research Institute research based on data from the FDA, Express Scripts, Catamaran, and Thomson Reuters³³

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